



## Open Letter to All Coal Miners, Coal Mine Operators and Contractors

### Take Time to Refocus on Safety

It's time for all of us, miners, mine operators and contractors to renew our commitment to sound and safe practices in our coal mines.

This year 15 fatal accidents have already occurred. With a joint effort by all to refocus on safety a repeat of these accidents could be prevented in the future and everyone can return home safely to their families. In addition to training, teamwork and communication, there must be recognition that *no short-term action should put any miner at risk of not achieving an accident free workday.*

We are writing to remind everyone that as vacation season is upon us and other summer activities are being planned, it becomes easier to be distracted from the task at hand. We are urging everyone to maintain a focus on safety by trying to anticipate hazards and, most importantly, thinking before acting and avoiding shortcuts.

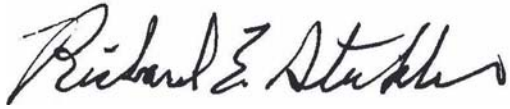
Enclosed are the MSHA Fatalgrams from the first 14 fatalities this year. Please read them and consider why these accidents happened and how you would have responded in similar circumstances.

In addition to these fatal accidents, four serious accidents as described in MSHA's preliminary accident reports, are listed below. Please review and discuss the safe work practices associated with these tasks and make a personal commitment to follow safe work procedures.

- On May 27, a section foreman was seriously injured while operating a continuous mining machine. The victim was looping cable onto the tail boom as he backed the machine out of a working place. The continuous mining machine unexpectedly slewed and crushed the victim between the tail boom and rib.
- On May 31, three miners were seriously injured when a crane collapsed. The crane was positioning a conveyor within a tube structure when the collapse occurred.
- On June 9, a miner was injured in a roof fall during retreat mining operations at an anthracite mine. The victim was shoveling loose coal toward the drag bucket runway when a piece of rock approximately 44 inches wide by 37 inches long by 7 inches thick fell and struck him on the head.

- On June 10, a contractor was injured at a shaft sinking operation. Metal sheeting was being hoisted when a wire rope broke allowing the metal to fall. The victim was struck in the head/upper body by a piece of metal.

Enclosures



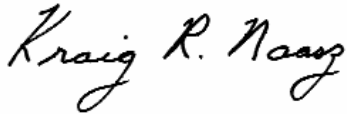
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Richard E. Stickler  
Acting Assistant Secretary of Labor  
for Mine Safety and Health



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Cecil E. Roberts  
President  
United Mine Workers of America



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Kraig R. Naasz  
President & CEO  
National Mining Association



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David Young  
President  
Bituminous Coal Operators' Association



**Fatality #1 - January 8, 2008**  
**Powered Haulage - Surface - Kentucky**  
**Cumberland River Coal Company - Blue Ridge Surface Mine**

**COAL MINE FATALITY** - On Tuesday January 8, 2008, a 29-year old truck driver with three years experience was fatally injured while attempting to dump spoil. The truck over-traveled the edge of the dump and rolled down the spoil slope approximately 140 feet.



**Best Practices**

- Provide and maintain adequate berms and other barriers of mid-axle height for dump sites.
- Routinely monitor work habits and examine work areas to ensure that safe work procedures are followed.
- Ensure equipment operators receive proper task training.
- Ensure work areas and dump sites are properly illuminated at night.
- Conduct pre-operational checks of equipment before placing into operation.
- Use seat belts when operating equipment.

This is the first fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there was one fatality reported in the coal mining industry. This is the first Powered Haulage fatality in 2008. At this time in 2007, there were no fatalities in this classification.

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**Fatality #2 - January 12, 2008**

**Fall of Face, Rib or Highwall - Surface - Texas**

**Luminant Mining Company LLC d/b/a Luminant Mining - Sulphur Springs Strip**

**COAL MINE FATALITY** - On Saturday, January 12, 2008, a fall of highwall accident resulted in fatal injuries to a shovel operator with 22 years of mining experience. The shovel was located parallel to and approximately 40 feet away from the toe of the highwall which was approximately 45 feet high. During a normal work break, the shovel operator climbed off the shovel. While the shovel operator was positioned between the toe of the highwall and the shovel, the highwall collapsed and pushed the victim against the track of the shovel. After returning to the pit and finding the shovel operator missing, a haul truck driver radioed for assistance. The shovel operator was found mostly covered in the sandy loam type material from the highwall. The victim was recovered but CPR was unsuccessful.



**Best Practices**

- Never work or position yourself near or under dangerous highwalls or banks.
- Promptly correct or post unsafe ground conditions.
- When unsafe ground conditions are found during on-shift examinations and are being corrected, notify all persons working in the area of the hazard and post the affected area until the unsafe condition is corrected.
- Do not work or position yourself between equipment and the highwall such that equipment may hinder escape from falls or slides.

This is the second fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there was one fatality reported in the coal mining industry. This is the first Fall of Highwall fatality in 2008. At this time in 2007, there were no fatalities in this classification.

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**Fatality #3 - February 1, 2008**  
**Machinery - Surface - Alabama**  
**Reed Minerals, Inc. - Jap Creek Mine**

**COAL MINE FATALITY** - On Friday, February 1, 2008, a 34-year old field mechanic (contractor) with 13 years of experience was fatally injured while troubleshooting a diesel engine on a bulldozer. A valve cover, rocker assembly, and fuel injector had been removed from the cylinder head. The victim was observing the valve lifters while the engine was turned-over to place the lifters in a better position for retrieval. The victim was struck and fatally injured by material expelled from the cylinder head as the engine was cranked.



Bulldozer and rear of service truck



Cylinder head

**Best Practices**

- Always wear eye protection when working near moving parts.
- Follow equipment manufacturer's protocols and procedures when working on equipment.
- Move to a safe location when there is a danger of high-pressure releases of fluids or objects.
- Always use the proper tools, parts, and equipment to safely perform the work.

This is the third fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were three fatalities reported in the coal mining industry. This is the first Machinery fatality in 2008. At this time in 2007, there were no fatalities in this classification.

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**Fatality #4 - February 18, 2008**

**Electrical - Facility - Pennsylvania**

**Consolidation Coal Company - Consolidation Coal Co 14-N Impoundment**

**COAL MINE FATALITY** - On Monday, February 18, 2008, a 51-year old outside service technician (contractor) with one year of experience was fatally injured while placing concrete barriers along a mine access road. A rubber-tired boom truck was being used to move the concrete barriers into place. The victim was electrocuted while standing on the ground, touching a suspended concrete barrier, when the boom came in contact with an energized 14,500 volt overhead power wire. The operator of the boom truck was treated and released.



**Best Practices**

- Ensure that booms or masts of equipment are not operated within 10 feet of any energized overhead powerline.
- Identify hazards associated with tasks prior to work assignments.
- Ensure that one person on the ground is designated to give signals to the crane operator and watch placement and proximity of the mast.
- Use non-conducting tag lines to steady loads when operating cranes where overhead power lines are present.

This is the fourth fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were three fatalities reported in the coal mining industry. This is the first Electrical fatality in 2008. At this time in 2007, there were no fatalities in this classification.

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**Fatality #5 - February 25, 2008**  
**Powered Haulage - Underground - Pennsylvania**  
**AMFIRE Mining Company LLC – Nolo**

**COAL MINE FATALITY** - On Monday, February 25, 2008, a 50-year old surveyor (contractor) with 8 years of total experience was fatally injured while surveying in an active underground continuous mining machine section. The victim was struck by a loaded shuttle car as it traveled through a run-through check curtain.



**Best Practices**

- Never position yourself in an area or location where equipment operators cannot readily see you.
- Before operating mobile equipment, always ensure that other miners are not in the area of your intended travel.
- Sound warnings when the operator's visibility is obstructed, such as when making tight turns, reversing direction, or approaching curtains.
- Wear reflective clothing to ensure high visibility when necessary to walk or work in the area of moving equipment.
- Perform surveying at times when the section is not in production.

This is the fifth fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were three fatalities reported in the coal mining industry. This is the second Powered Haulage fatality in 2008. At this time in 2007, there were no fatalities in this classification.



**Fatality #6 - March 12, 2008**  
**Machinery - Mill/Prep Plant - West Virginia**  
**Appalachian Fuels, LLC - Alloy Prep Plant #1**

**COAL MINE FATALITY** - On Wednesday, March 12, 2008, a 47-year old mechanic/contractor with 21 years of experience was fatally injured while attempting to remove a front guard assembly (belly pan) from a bulldozer. The victim was positioned beneath the bulldozer, removing mounting bolts from the bulldozer guard. The guard was supported by a chain attached to a remote-operated truck-mounted crane. As the bolts were removed, the chain support slipped and the guard fell.



**Best Practices**

- Always follow the equipment manufacturer's recommended maintenance procedures when conducting repairs to machinery.
- Install blocking materials before mounting bolts are removed from machinery components which may fall during disassembly.
- Conduct training for miners assigned to new work tasks to ensure they are aware of the health and safety aspects and safe work procedures related to the assigned tasks.

This is the sixth fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were four fatalities reported in the coal mining industry. This is the second Machinery fatality in 2008. At this time in 2007, there was one fatality in this classification.

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**Fatality #7 - April 18, 2008**  
**Machinery - Underground - Pennsylvania**  
**Rosebud Mining Company - Little Toby Mine**

**COAL MINE FATALITY** - On Friday, April 18, 2008, a 43-year old continuous miner operator with 3½ years experience was fatally injured while operating a continuous miner with an attached mobile bridge conveyor system. As the victim was positioning the continuous miner in a crosscut turning right, the inby mobile bridge operator felt an unusual bouncing of the bridge and failed to get a radio response from the miner operator. The bridge operator shut the system down using the emergency stop switch and crawled toward the face and discovered the victim pinned between the basket of the bridge and the left rib.



**Best Practices**

- Frequently review, retrain, and discuss avoiding the **"RED ZONE"** areas when operating or working near a remote controlled continuous mining machine.
- Follow established safe work practices and provide periodic training along with checks to ensure that the safe work practices have been properly implemented.
- Pursue new technology such as proximity detection to protect personnel and eliminate accidents of this type.
- Minimize the number of miners working or traveling near operating systems and maintain an effective means of communications between miners and system operators.

This is the seventh fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were seven fatalities in the coal mining industry. This is the third Machinery fatality in 2008. At this time in 2007, there was one fatality in this classification.

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**Fatality #8 - April 22, 2008**  
**Fall of Roof or Back - Underground - Virginia**  
**Osaka Mining Corporation - Mine No. 1**

**COAL MINE FATALITY** - On Tuesday, April 22, 2008, a 61-year old roof bolting machine operator with 30 years of mining experience was fatally injured while observing a continuous mining machine producing coal at the working face. A rock approximately 36" x 72" x (0"-14") fell from the roof, striking the victim and the continuous mining machine operator. The victim was fatally injured by the roof fall and the continuous mining machine operator received nonfatal injuries.



**Best Practices**

- Conduct a thorough visual examination of the roof, face, and ribs immediately before any work is performed and thereafter as conditions warrant.
- Be alert to any change of roof conditions.
- Identify and remove loose roof material from a safe position.
- Mine personnel not essential to the specific activity should remain outside the work zone.

This is the eighth fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were six fatalities reported in the coal mining industry. This is the first Roof Fall fatality in 2008. At this time in 2007, there were two fatalities in this classification.

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**Fatality #9 – May 16, 2008**  
**Electrical - Underground - West Virginia**  
**Aracoma Coal Company, Inc. - Aracoma Alma Mine #1**

**COAL MINE FATALITY** - On Friday, May 16, 2008, a 24 year old electrician with 4 years of mining experience was fatally injured when he cut into an energized shuttle car trailing cable. The victim was attempting to make an electrical repair on the shuttle car when he used a cable cutter tool to cut into an energized lead.



**Best Practices**

- Personally lock-out and tag-out electrical circuits before you perform electrical work on a cable or component.
- Do not rely on anyone else to deenergize or disconnect a circuit.
- Maintain multiple locks and tags available to lock circuits.
- Maintain electrical meters and testing instruments in good condition to verify that the circuit is deenergized before beginning work.
- Communicate your intentions to work on an electrical circuit to ensure the circuit is, and remains, protected.

This is the ninth fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were six fatalities reported in the coal mining industry. This is the second Electrical fatality in 2008. At this time in 2007, there were no fatalities in this classification.

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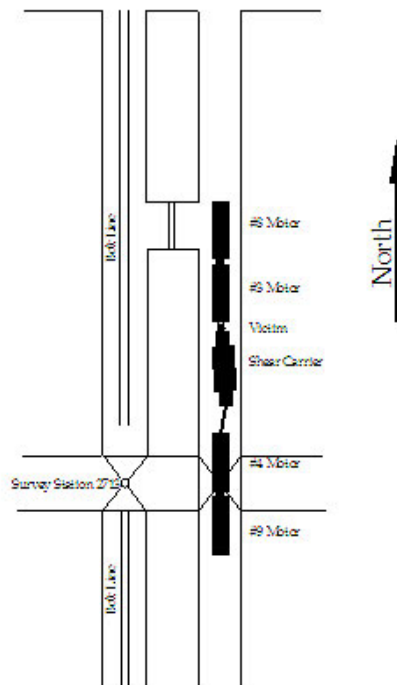


**Fatality #10 – May 22, 2008**

**Powered Haulage - Underground - Alabama**

**Oak Grove Resources, LLC - Oak Grove Mine**

**COAL MINE FATALITY** - On Thursday, May 22, 2008, a 64-year old underground locomotive (motor) operator with 25 years experience was fatally injured when he was pinned between his motor and a longwall shearer being transported on a rail type carrier. The victim, three other operators, and a foreman, were transporting the longwall shearer body to a longwall setup section when the carrier derailed as it was moving upgrade. The victim dismounted the #3 motor to assist in rerailing the carrier. He was between the motor and the carrier when the motor(s) slid or rolled back, crushing him between the shearer body and locomotive.



**Best Practices**

- Never place yourself between rail cars/equipment unless positive stop blocks are in place.
- Always set parking brakes when getting off mobile track equipment.
- Pull, do not push rail cars.
- Always be aware of your location in relation to mobile equipment.

This is the tenth fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were seven fatalities reported in the coal mining industry. This is the third Powered Haulage fatality in 2008. At this time in 2007, there were no fatalities in this classification.





**Fatality #11 – May 30, 2008**  
**Powered Haulage - Underground - West Virginia**  
**Wolf Run Mining Company - Sentinel Mine**

**COAL MINE FATALITY** - On Friday, May 30, 2008, a general inside laborer with four weeks experience was fatally injured when he was struck by a battery powered scoop. The victim was assisting two other miners repair a haul road. The scoop operator had just changed out the scoop batteries and picked up a load of gravel. The victim was traveling on foot and was being followed by the scoop and a diesel road grader. While in route, the scoop operator inadvertently struck the victim causing fatal injuries.



**Best Practices**

- Remain a safe distance from moving equipment until it has passed.
- Walk behind moving mobile equipment when traveling in the same entry.
- When operating mobile equipment, ensure that other workers are in a safe area before moving the equipment.
- When necessary to walk or work in the area of moving mobile equipment, wear reflective clothing to ensure a high visibility.
- Always assume the mobile equipment operator has not seen you unless eye contact is confirmed.

This is the eleventh fatality reported during calendar year 2008 in the coal mining industry. As of this date in 2007, there were seven fatalities reported in coal mining. This is the fourth fatality classified as powered haulage in 2008. There were no fatalities in this category at this time in 2007.

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**Fatality #12 – June 3, 2008**  
**Fall of Roof or Back - Underground - Indiana**  
**Gibson County Coal, LLC - Gibson Mine**

**COAL MINE FATALITY** - On Tuesday June 3, 2008, a 25 - year old roof bolting machine operator with 2 years of mining experience was fatally injured by a fall of roof. A rock measuring approximately 5' in length x 11' in width and 0" to 10" in thickness fell from beyond permanent support and cantilevered outby striking the bolter operator and pinning him between the foot cylinder of the pressurized ATRS.



**Best Practices**

- Never travel inby supported areas.
- Always conduct a through visual examination of the roof, face and ribs immediately before work is performed and thereafter as conditions dictate.
- Always stay alert for changing conditions in your work area.
- Scale any loose or hazardous roof material using proper equipment and scale from a safe location.
- Know and follow the approved roof control plan.

This is the twelfth fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were six fatalities reported in the coal mining industry. This is the second roof fall fatality in 2008. At this time in 2007, there were two fatalities in this classification.

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**Fatality #13 – June 3, 2008**  
**Machinery - Open Pit - Kentucky**  
**Premier Elkhorn Coal Company - Job #49**

**COAL MINE FATALITY** - On Tuesday, June 3, 2008, a 33-year old tree cutter (contractor) with 10 years experience was fatally injured while cutting trees in advance of a surface mining operation. The victim had made a notch cut on a 24" diameter tree and was in the process of completing the back cut when the tree slabbed from the stump approximately 16 feet high then fell on the victim. The tree contained a hollow center which promoted the slabbing.



**Best Practices**

- Examine the area around the tree to be cut for hazards from previously felled trees, vines, underbrush, etc.
- Ensure that a clear escape route is present at a 45 degree angle away from the tree.
- Always make an open face (notch) cut in the direction the tree should fall. This cut should be of adequate depth (25% of tree diameter) and the two cut angles should total 90 degrees.
- Use bore cutting whenever possible, leaving a hinge equaling 10% of the tree diameter to guide the fall of the tree and hold it to the stump during the majority of the tree's fall.
- The final cut should be level.
- Chainsaw bar should be of sufficient length to reach through the diameter of the tree.

This is the 13<sup>th</sup> fatality reported in calendar year 2008 in the coal mining industry. As of this date in 2007, there were seven fatalities reported in the coal mining industry. This is the fourth Machinery fatality in 2008. At this time in 2007, there was one fatality in this classification.

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**Fatality #14 – June 5, 2008**  
**Powered Haulage - Underground - West Virginia**  
**Consolidation Coal Company - Robinson Run No 95**

**COAL MINE FATALITY** - On Thursday, June 5, 2008, a lead motorman (locomotive operator) was fatally injured while transporting supplies on two mine rail cars. The tail motorman, traveling behind the trip approximately 300 to 400 feet, discovered the victim between the clearance side of the track and the mine rib along the haulage. The victim's locomotive continued traveling in by and derailed approximately 1,400 feet from the location of the victim. The track haulage was down grade in the area where the accident occurred.



**Best Practices**

- Apply sand to mine rails to assure locomotive operators can safely stop.
- Assure locomotives are coupled to each end of the trip to maintain control of the load.
- Assure the weight of the load being transported does not exceed the braking capacity of the haulage equipment.
- Always conduct an adequate pre-operational examination of haulage equipment prior to use.

This is the fourteenth fatality reported during calendar year 2008 in the coal mining industry. As of this date in 2007, there were seven fatalities reported in coal mining. This is the fifth fatality classified as Powered Haulage in 2008. There were no fatalities in this category at this time in 2007.

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